EXCEL VERSION

MS-2004

SCHEDULE B	EXPENSE RECONCILIATION			PROVIDER NUMBER 0
	LN#	(1) BOOKS	(2) FED TAX RETURN	(3) COST REPORT
TOTAL EXPENSES PER BOOKS	601	$0		
TOTAL EXPENSES PER FEDERAL TAX RETURN	602		$0	
TOTAL EXPENSES PER COST REPORT (LINE 599, COLUMN 2)	603			$0
EXPENSES ON BOOKS OR FEDERAL TAX RETURN NOT ON COST REPORT				
SPECIFY	604	$0	$0	
SPECIFY	605	$0	$0	
EXPENSES ON COST REPORT NOT ON BOOKS OR FEDERAL TAX RETURN				
SPECIFY	606			$0
SPECIFY	607			$0
TOTAL (SHOULD BE EQUAL)	608	$0	$0	$0

SCHEDULE C — **STATEMENT OF OWNERS AND RELATED PARTIES**

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES.
SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES.
FOR FURTHER CLARIFICATION SEE KAR 30-10-1a AND 30-10-24.

NAME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION AMOUNT	(5) DISTRIBUTION LINE#
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
TOTALS (SHOULD BE EQUAL)			$0		$0	

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF 121, 122, 221, AND 321

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0

SCHEDULE D **STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE**

	LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	REPORTED ON LINE	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
651											
652											
653											
654											
655											
656											
657											
658											
659											
660											
661											
662											
663											
664											
665											
666											
667 TOTALS:											
	LINE 160								$0		$0
	LINE 401								$0		$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 160 & 401. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

TN#MS02-28 Approval date MAR 17 2003 Effective Date 12/31/02 Supersedes TN#MS02-06

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SCHEDULE E	BALANCE SHEET			PROVIDER NUMBER 0	
		BEGINNING OF PERIOD		END OF PERIOD	
ASSETS	LN#	(1)	(2)	(3)	(4)
CASH	701		$0		$0
ACCOUNTS RECEIVABLE	702	$0		$0	
LESS: ALLOWANCE FOR DOUBTFUL ACCOUNT	703	$0	$0	$0	$0
INVENTORIES & SUPPLIES	704		$0		$0
ALL LOANS TO OFFICERS, OWNERS, AND RELATED PARTIES	705		$0		$0
ALL ASSETS NOT RELATED - RESIDENT CARE	706		$0		$0
ASSETS HELD FOR INVESTMENT	707		$0		$0
NURSING HOME PLANT & EQUIPMENT:					
BUILDING	708	$0		$0	
LESS: ACCUMULATED DEPRECIATION	709	$0	$0	$0	$0
EQUIPMENT	710	$0		$0	
LESS: ACCUMULATED DEPRECIATION	711	$0	$0	$0	$0
LEASEHOLD IMPROVEMENTS	712	$0		$0	
LESS: ACCUMULATED DEPRECIATION	713	$0	$0	$0	$0
LAND	714		$0		$0
OTHER	715		$0		$0
OTHER	716		$0		$0
TOTAL ASSETS	719		$0		$0
LIABILITIES & OWNER'S EQUITY					
ACCOUNTS PAYABLE	721		$0		$0
OTHER CURRENT LIABILITIES	722		$0		$0
ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	723		$0		$0
MORTGAGE PAYABLE	724		$0		$0
OTHER LONG TERM LIABILITIES	725		$0		$0
OWNER'S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS - SEE INSTRUCTIONS)					
	727		$0		$0
	728		$0		$0
	729		$0		$0
TOTAL LIABILITIES & OWNER'S EQUITY	730		$0		$0

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		PROVIDER NUMBER 0	
SCHEDULE F BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION			
BALANCE AT BEGINNING OF PERIOD - LINE 727, 728, & 729, COLUMN 2	751		$0
INCREASES:			
REVENUE PER LINE 822, COLUMN 1	752	$0	
INVESTMENT BY OWNER	753	$0	
TRANSFERS FROM CENTRAL OFFICE	754	$0	
COMMON STOCK SOLD	755	$0	
OTHER (SPECIFY)	756	$0	
OTHER (SPECIFY)	757	$0	
TOTAL INCREASES	758		$0
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 599, COLUMN 2	761	$0	
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	762	$0	
TRANSFERS TO CENTRAL OFFICE	763	$0	
DIVIDENDS PAID TO STOCKHOLDERS	764	$0	
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	765	$0	
OTHER (SPECIFY)	766	$0	
OTHER (SPECIFY)	767	$0	
TOTAL DECREASES	768		$0
BALANCE AT END OF PERIOD - LINE 727, 728, & 729, COLUMN 4	769		$0

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SCHEDULE G REVENUE STATEMENT			PROVIDER NUMBER 0	
	LN#	REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	LINE NUMBER OF RELATED EXPENSE (3)
ROUTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	801	$0		
MEDICAID RESIDENTS & PATIENT LIABILITY	802	$0		
MEDICARE RESIDENTS (PART A)	803	$0		
VETERAN ADMINISTRATION RESIDENTS	804	$0		
OTHER RESIDENTS (SPECIFY)	805	$0		
PHARMACY - DRUGS & MEDICATIONS	806	$0		
ROUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENTS	807	$0		
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	808	$0	$0	
BEAUTY/BARBER SHOP	809	$0	$0	
RESIDENT PURCHASES/NON ROUTINE ITEMS SOLD	810	$0	$0	
PURCHASE DISCOUNTS, RETURNS, REFUNDS & ALLOWANCES	811	$0	$0	
OTHER SUPPLIES SOLD	812	$0	$0	
PROGRAM REIMBURSEMENTS & TAX CREDITS	813	$0	$0	
INVESTMENT/INTEREST INCOME	814	$0	$0	
VENDING MACHINE REVENUE	815	$0	$0	
CHILD DAY CARE INCOME	816	$0	$0	
ADULT DAY CARE/TREATMENT INCOME	817	$0		
MEDICARE PART B	818	$0		
HOME HEALTH CARE REVENUE	819	$0	$0	
NON-NURSING FACILITY RESIDENTIAL INCOME	820	$0	$0	
OTHER (SPECIFY)	821	$0	$0	
TOTALS	822	$0	$0	

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PROVIDER NUMBER 0

SCHEDULE H(1) STATEMENT OF RELATED ADULT CARE HOME INFORMATION

851 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP, LESS THAN 5%, AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATION? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE H(2). IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
855			
856			
857			
858			
859			
860			
861			
862			
863			
864			
865			

IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

SCHEDULE H(2) STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

INDICATE BELOW IF YOU PARTICIPATE IN ANY NON-RESIDENT RELATED ACTIVITES AT THE FACILITY FOR WHICH YOU ARE REPORTING. ATTACH AN ADDITIONAL SCHEDULE IF NECESSARY.

	(1) NON-RESIDENT RELATED ACTIVITY?		(2) WERE ADJUSTMENTS MADE ON SCHEDULE A FOR THIS ACTIVITY?
866	CHILD DAY-CARE	☐ YES ☐ NO	☐ YES ☐ NO
867	ASSIST. LIVING/RHC	☐ YES ☐ NO	☐ YES ☐ NO
868	HOME HEALTH CARE	☐ YES ☐ NO	☐ YES ☐ NO
869	HOME DELIVERED MEALS	☐ YES ☐ NO	☐ YES ☐ NO
870	OTHER (PLEASE SPECIFY) _____		☐ YES ☐ NO
	_____		☐ YES ☐ NO
	_____		☐ YES ☐ NO

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		PROVIDER NUMBER 0	
SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE			
901	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?	☐ YES	☐ NO
902	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?	☐ YES	☐ NO
	IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 913.		

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
905			
906			
907			
908			
909			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 902-909 FOR COMPLEX CAPITAL STRUCTURES.

911	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED**	☐ YES	☐ NO
912	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
913	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
914	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION? (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
915	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO
916	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENT NOW**	☐ YES	☐ NO

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PROVIDER NUMBER 0

SCHEDULE J EMPLOYEE TURNOVER REPORT

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	PART-TIME	(7) EMPLOYEES RETAINED
951	ADMINISTRATOR	0	0	0	0			
952	CO-ADMINISTRATOR	0	0	0	0			
953	OTHER ADMINISTRATIVE	0	0	0	0			
954	PLANT OPERATING	0	0	0	0			
955	DIETARY	0	0	0	0			
956	LAUNDRY	0	0	0	0			
957	HOUSEKEEPING	0	0	0	0			
958	REGISTERED NURSES	0	0	0	0			
959	LPN	0	0	0	0			
960	LICENSED MH TECH	0	0	0	0			
961	AIDES	0	0	0	0			
962	PHYSICAL THERAPIST	0	0	0	0			
963	SPEECH THERAPIST	0	0	0	0			
964	OCCUPATIONAL THERAPIST	0	0	0	0			
965	RESPIRATORY THERAPIST	0	0	0	0			
966	PSYCH THERAPIST	0	0	0	0			
967	RECREATION THERAPIST	0	0	0	0			
968	RESIDENT ACTIVITY	0	0	0	0			
969	SOCIAL WORKER	0	0	0	0			
970	MEDICAL RECORDS	0	0	0	0			
971	OTHER HEALTH CARE	0	0	0	0			
972	TOTAL ALL CLASSIFICATION	0	0	0	0	0	0	0

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAVE TWO COPIES OF PAGE 16 BEEN PRINTED AND SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORT SCHEDULES COMPLETE?
3. ARE THE DISKETTES FOR THE COST REPORT AND THE CENSUS REPORT (AU-3902) ENCLOSED?
   PLEASE NOTE THAT YOU DO NOT NEED TO INCLUDE HARD COPIES OF THE COST REPORT
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?
   (a) WORKING TRIAL BALANCE AND SUPPORTING SCHEDULES USED TO PREPARE THE COST REPORT
   (b) DEPRECIATION SCHEDULE
   (c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES
   (d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE)
   (e) DISKETTE OF CENSUS SHEETS (AU-3902)
   (f) DOCUMENTATION OR RESOLUTION STATING PERSON'S AUTHORITY TO SIGN DECLARATION STATEMENT IF NOT AN OWNER OR PARTNER
   (g) WORK PAPER FOR THERAPY EXPENSE ADJUSTEMENTS
   (h) COST ALLOCATION SCHEDULES FOR OTHER NON NURSING FACILITY PROGRAMS

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DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR 0 0
FOR THE COST REPORT PERIOD BEGINNING 1/0/1900
AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	FAX #

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

State of Kansas
Department of Social & Rehabilitation Services (SRS)/
Department on Aging (KDOA)

INSTRUCTIONS FOR COMPLETING THE NURSING FACILITY FINANCIAL AND STATISTICAL REPORT (FORM MS-2004)

PURPOSE

The purpose of this report is to obtain the resident-related costs incurred by nursing facilities (NF) and nursing facilities-mental health (NF-MH) in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and NF reimbursement can be found in the Kansas Administrative Regulations (KAR), Chapter 30, Part 10.

SUBMITTAL INSTRUCTIONS

1. One blank Form MS-2004 on diskette, Nursing Facility Financial and Statistical Report, will be sent by the Program and Policy Commission to each nursing facility in the Kansas Medical Assistance Program before the end of the home's reporting period.

2. Send the completed form MS-2004 and form AU-3903 (Census Summary) for each month of the reporting period on diskette, along with two printed and signed copies of page 16 of the MS-2004 to the following address:

Kansas Department on Aging
New England Building
503 S. Kansas Avenue
Topeka, Kansas 66603-3404
Attention: Director, Nursing Facility Rate Setting

3. All inquires on completion of these forms should be directed to the Director, NF Rate Setting at (785) 296-0703.

GENERAL

The cost report is organized by the following sections and numbering schemes. Not all line numbers within each range are used.

General Information	Lines 1-99
Schedule A, Operating Cost Center	Lines 101-199
Schedule A, Indirect Health Care Cost Center	Lines 201-299
Schedule A, Direct Health Care Cost Center	Lines 301-399
Schedule A, Ownership Cost Center	Lines 401-499
Schedule A, Non-Reimbursable/Non-Resident Related Expense Items	Lines 501-599
Schedule B, Expense Reconciliation	Lines 601-650
Schedule C, Statement of Owners and Related Parties	Not Numbered
Schedule D, Statement Related to Interest...	Lines 651-699
Schedule E, Balance Sheet	Lines 701-750
Schedule F, Beginning & Ending Residual Balances Reconciliation	Lines 751-799
Schedule G, Revenue Statement	Lines 801-850
Schedules H(1), Related ACH Info, and H(2), Non-Resident Related...	Lines 851-899
Schedule I, Fixed Asset, Depreciation & Amortization Questionnaire	Lines 901-950
Schedule J, Employee Turnover Report	Lines 951-999

1. Complete the forms accurately and legibly. Any report that is incomplete or is not legible shall be promptly returned to the provider. Failure to submit a complete cost report shall result in suspension of payment until the complete cost report is received.

2. All amounts must be rounded to the nearest dollar and sum to the total.

3. **DO NOT** add lines to the forms. Use "OTHER" lines for resident-related expenses not designated on the Expense Statement, Schedule A. Attach a schedule if necessary.

4. **DO NOT** cross out or re-title lines on the forms. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation. The attachment should be sorted by cost report line number and should include subtotals.

5. Enter the ten (10) digit SRS provider number on page 1 and in the blank space provided at the top of each schedule. **DO NOT** use your federal number assigned by the Dept. of Health & Environment.

6. Use the accrual method of accounting in reporting financial data. Revenues are reported in the period when earned, and not when received, and expenses are reported when incurred, not when paid.

7. Estimates of revenues and expenses are not acceptable.

8. All cost reports, historical or projected, must be for a period of 12 consecutive months except as provided in KAR 30-10-17. Providers who filed a projected cost report must file a historical report for the projection period and a historical report for the first calendar year following the end of the projection period.

9. All calendar year cost reports shall be received by the agency no later than the close of business on the last working day of February. All other historical cost reports covering a projection status period shall be received by the agency no later than the close of business on the last working day of the second month after the reporting period ends. The provider may request a one month extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 30-10-17.

10. Each NF/NF-MH must maintain adequate accounting and/or statistical records. Inadequate record keeping is cause for suspension of payments. KAR 30-10-15b. If non-NF/NF-MH program expenses have been commingled with the NF or NF-MH, see the instructions for provider adjustments on Schedule A, Expense Schedule.

11. Reimbursement rates (per diem) for NF: The per diem rate of reimbursement for those facilities participating in the Kansas Medical Assistance program is based on the reported costs and resident days as adjusted by a desk review of the cost report and payment limitations. Each cost report is also subject to a field audit to arrive at a final settlement for the period upon which the per diem rate was based.

12. **KANSAS ADMINISTRATIVE REGULATIONS:** Copies of the regulations governing NF Kansas Medical Assistance reimbursement may be obtained at a cost by sending a request to the Department on Aging to the address given in the submittal instructions. NOTE: SINCE THE REGULATIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM MS-2004 FOR SUBMISSION.

13. **NURSING FACILITIES ATTACHED TO HOSPITALS:** A nursing facility that is attached or associated with a hospital and shares expenditures shall submit the cost report (MS-2004), census sheets (AU-3902), and the following Medicare schedules: W/S A, A-6, A-8, B Part I and B-1. Also include the working trial balance that includes both the hospital and the long-term unit. A "step-down process" will be run using the statistical information from W/S B-1 and the net expenses for cost allocation from Column 0 on W/S B Part 1. This will provide the indirect long-term care unit costs. Based on the long term care cost to net expense ratio, each department cost will be allocated to the appropriate line of the cost report. The total cost reported on the cost report should equal the long-term care total, Column 25, on W/S B Part 1.

COST REPORT INSTRUCTIONS

COVER PAGE

PROVIDER IDENTIFICATION:

Lines 11-20: Complete these lines as indicated on the report form.

Lines 21-25: Check only one box.

Line 21 Check if the cost data is for the calendar year report period and does not include any portion of a projection period.

Line 22 Applies to projected cost reports for new providers that are not occupying a newly constructed facility.

Line 23 Applies only to projected cost reports related to newly constructed facilities. If a provider occupies a newly constructed facility they should check this box.

Line 24 Applies to providers filing historical cost reports for the same period as their projection year or the first year of operation for a change of provider.

Line 25 Applies only to providers in the process of converting from the projection period to the calendar year and the report period includes a portion of the projection period.

Lines 26-32: Check only one box. Check the type of business organization which most accurately describes your provider status or explain on line 33, Other. Limited Liability Companies should check the box that matches their declaration for tax purposes.

NF and NF-MH:

Lines 43-43d: Enter the number of licensed NF or NF-MH beds under the BED COUNT column. Then calculate and record the number of bed days at that bed count (multiply the bed count by the number of calendar days this count is maintained, see example below). If a change in the number of beds has occurred during the reporting period, show the increase or decrease, the date of the change, the new bed count, and the bed days at that count.

Example of Bed Days calculation:

Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30 - 181 days x 20 beds =	3,620 bed days
July 1 to December 31- 184 days x 25 beds =	4,600 bed days
	8,220 bed days for period

Line 45: Record the bed count as of the ending date of the cost report period.

Line 46: **Total Bed Days** – Record the sum of the BED DAYS AT THIS COUNT column from lines 43-43d.

Line 48: **Total Resident Days** - The total number of resident days shall be determined in accordance with KAR 30-10-28. A resident day means that period of service rendered to a resident between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas Medical Assistance or non-Kansas Medical Assistance resident who was not in the facility (KAR 30-10-1a). If both the admission and discharge occur on the same day, it shall count as a resident day. If the provider does not make refunds on behalf of a resident for unused days in the case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day. Any bed days paid for the resident before an admission date shall not be counted as a resident day. The total resident day count for the cost report period shall be accurate. An estimate of the days of care provided shall not be acceptable. **The total resident days must agree with the 12 month total as submitted on the diskette of the Form AU-3902.**

Day care and day treatment shall be counted as one resident day for 18 hours of service. The recipients of day care/treatment shall be listed on the monthly census summary diskette of the Form (AU-3903) with the number of hours reflected on the appropriate day column.

Occupancy Percentage: Agency staff will determine this percentage.

Line 48a: **Total Kansas Medical Assistance Days** - Enter the total number of **Kansas Medical Assistance** days reported on the diskette of the Form AU-3902. Partial, as well as full paid days must be included (please refer to KAR 30-10-28).

Line 48b: **Total Medicare Days** - Enter the total Medicare days in the report period.

OTHER FACILITY BEDS:

Lines 49: **Assisted Living/Res. Care** - Enter the number of beds for assisted living and residential health care. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 50: **Unlicensed Beds** - Enter the number of unlicensed beds i.e., apartments within the facility. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 51: Enter the total number of other residential days with shared NF/NF-MH costs. The total other residential days must agree with the 12 month total as submitted on the diskette of the Form AU-3903.

Line 52: Check the appropriate box regarding Medicare certified beds.

Line 53: Please indicate if the facility is a hospital based long term care (LTC) facility or a free standing facility.

MAR 17 2003

TN#MS02-28 Approval date _____ Effective Date 12/31/02 Supersedes TN#MS02-06

SCHEDULE A - EXPENSE STATEMENT

Attach a copy of the working trial balance used to prepare the cost report.

Total Annual Hours Paid - Column 1 - Enter the total hours paid to the employees on each of the salary lines for the reporting period. Employees shall be reported on the appropriate salary line for their position classification.

Per Books or Federal Tax Return - Column 2 - Report the expenses reflected in the accounting records under the appropriate cost center (i.e., Operating, Indirect Health Care, Direct Health Care, Ownership and Non-Reimbursable). The total of all the expense lines (Column 1 - Line 599) shall reconcile to the income tax return and/or the accounting records.

Provider Adjustments - Column 3 - Enter the necessary adjustments to the expenses reported in Column 2 that are not resident-related according to the regulations and/or offset expense recoveries reported in the Revenue Statement, Schedule G. Attach a schedule if necessary.

Resident Related Expense - Column 4 - Enter the difference between Column 2 and Column 3. Please complete Column 4 even if no adjustments were made in Column 3, except for lines 501 through 514.

State Adjustments/Adjusted Resident Related Expenses - Columns 5 & 6 - Leave blank - FOR AGENCY USE ONLY

Expense Lines

General: All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Operating cost center. Therefore, the expense for telephone lines to the nurses' station shall not be reported in the Direct or Indirect Health Care cost center. See specific line instructions for more detail. **DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.**

The specific instructions, which follow, do not cover each line item of the expense statement, but are designed to cover items that may require additional explanation or examples.

All Salaries - Lines - 101-104, 201-213, and 301-306, - Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). These lines, plus the owner/related party compensation lines, shall reconcile to your IRS 941 Report forms as adjusted by benefits or other bonuses.

Each facility must have a full time licensed administrator. Non-owner/related party administrator compensation shall be reported on line 101. Owner/related party administrator compensation shall be reported on line 121. A hospital-based long term care unit, under the jurisdiction of a hospital administrator, must report a percentage of the administrator's salary on line 101, and the salary of the staff person serving as an assistant administrator on line 102. Salaries and benefits of the administrator and co-administrator paid as central office costs shall be reported on lines 101, 102, and 119.

Report the salaries of the Direct Health Care Cost Center personnel on the most appropriate classification for lines 301-306. In the Indirect Health Care Cost Center, lines 205-210, are for reporting salaried employee therapists. DO NOT REPORT CONSULTANTS ON THESE LINES.

Employee Benefits - Lines 119, 219, and 319- Allocate employee benefits to the benefit lines in each cost center based on the percentage of gross salaries or the actual amount of expense incurred in each center. Employee benefits, if offered to substantially all employees may include, but are not limited to:

1) Employer's share of payroll taxes

2) State and federal unemployment contributions
3) Workers' compensation insurance
4) Group health and life insurance
5) Employee "non-cash" gifts
6) Moving/relocation expenses
7) Employee retirement plans
8) Employee parties - except alcoholic beverages
9) Profit sharing
10) Physical examinations
11) Malpractice insurance that specifically protects employees. This shall be specifically identified on the insurance bill from the agent.
12) Employee Uniforms
13) Employee Meals

Employee benefits shall not include:

1) Employee cash bonuses and/or incentive awards - these payments shall be considered additional compensation and be reported on salary lines.

2) Benefits given to owner/related parties - these benefits shall be reported on the owner/related party employee benefits lines (125, 225, 325).

Employee benefits with restrictions include:

1) Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported.

Contracted Labor - Lines130, 230 and 330. These lines shall be used to report all contract labor for services that would normally be provided by employees listed in the cost center.

Consultants - Lines131, 231-238, and 331. Consulting fees paid to related parties are subject to the restrictions of KAR 30-10-1a and KAR 30-10-23b (c) and (d).
Report fees paid to professionally qualified non-salaried consultants. List the titles of consultants reported on line 238.

Owners and Related Party Compensation - Lines121, 122, 221, and 321. - Record the amount earned and reported to IRS for owner/related parties. In order to be allowed, the compensation must be paid within 75 days after close of the cost report period. The amount reported must be in agreement with entries made in Schedule C. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration for managerial and administrative functions, professionally qualified health care services and other services related to the operation of the nursing facility, and was rendered in connection with resident care. All compensation paid to an owner/related party shall appear on the appropriate lines above regardless of the label placed on the services rendered (See KAR 30-10-24).

"Other" - Lines 181 and 281 - "Other" or blank lines have been provided in the operating and indirect health care cost centers. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report. **Failure to do so can cause unnecessary delay in the processing of your cost report.**

Management Consultant Fees - Line 131 - Report fees paid to non-related party management consultants. If the management services company is owned or controlled by the company or person(s) that own or control the facility, actual cost of the management company must be reported as central office costs and/or owner's compensation. See instructions for reporting central office costs - line 151.

Allocation of Central Office Costs - Line 151 - All providers with more than one facility and pooled administrative costs shall report allocated costs on line 151. All facilities, including the central office, must